BabyNet
South Carolina's Early Intervention System
SC DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

Family Hearing and Vision Report

Child's Name _____ Date of Birth _____

Interviewer Name _____ Date completed _____

1. Previous Testing

VISION

Do you have any concerns about your child's ability to see?	☐ Yes	☐ No	☐ Not Sure
Has your child been referred to an eye doctor?	☐ Yes	☐ No	☐ Not Sure
Has your child been tested by an eye doctor?	☐ Yes	☐ No	☐ Not Sure

If YES: Date Tested _____

Diagnosis/recommendations for follow up: _____

Provider Name _____

Comments:

HEARING

Do you have any concerns about your child's ability to hear?	☐ Yes	☐ No	☐ Not Sure
Has your child been referred to an audiologist?	☐ Yes	☐ No	☐ Not Sure
Has your child been tested by an audiologist?	☐ Yes	☐ No	☐ Not Sure
Has your child been diagnosed with an expressive communication delay?	☐ Yes	☐ No	☐ Not Sure
Did your child have a Newborn Hearing (*First Sound*) Screening?	☐ Yes	☐ No	☐ Not Sure

If YES, ☐ Passed (both ears) ☐ Failed (one or both ears)

☐ Referrals made _____

Diagnosis/recommendations for follow up: _____

Provider Name _____

Comments:

IF A DIAGNOSIS HAS BEEN MADE STOP HERE.
ENTER FINDINGS ON IFSP FORM (Section 5)

2. Risk Factors

Do any problems with vision or hearing run in the child's family? *(Blood relatives experiencing hearing or vision problems as young children)*	☐ Yes	☐ No	☐ Don't Know
Were there any problems during pregnancy, birth, or right after the child was born? *(Known trauma, meningitis, maternal infection, cerebral palsy, hydro/microcephaly)*	☐ Yes	☐ No	☐ Don't Know
Were there any problems identified or illnesses that could affect development?	☐ Yes	☐ No	☐ Don't Know
Has your child been diagnosed with any genetic, medical, or developmental conditions or delays? *(Down's Syndrome, Fetal Alcohol Syndrome, CHARGE, Prader-Willi, Hurler)*	☐ Yes	☐ No	☐ Don't Know

PLACE LABEL HERE

3. Functional Skills

Ask ALL questions.

VISION-RED FLAG QUESTIONS	YES*	NO
Does light seem to bother your child? (squint, cry, turn away)	☐	☐
Does your child often tilt or turn their head when looking at an object?	☐	☐
Does your child hold objects very close (1"-2") when looking at them?	☐	☐
Does your child seem overly interested in staring at lights?	☐	☐
Does your child seem to be looking under, over or beside objects/persons rather than looking directly at them?	☐	☐
Does your child tend to ignore toys unless they light up or make noise/music?	☐	☐
Does one/both eye(s) turn in or out, especially when the child is tired or ill?	☐	☐
Do you have concerns about how your child' s eyes appearance *(size of eyeball, eye Swelling, drooping of one eyelid, excessive tearing, blinking, eyes don't move together)*?	☐	☐

(* Referral indicated)

Ask questions closest to the child's adjusted age and younger

HEARING-RED FLAG QUESTIONS	AGE	YES*	NO
Does your child often fail to respond to typical sounds in their environment *(dog bark, door bell, item dropped behind)*?	3+ mos	☐	☐
Does your child often fail to respond to their name or a noise that you would expect them to hear *(pan dropping)*?	3+ mos	☐	☐
Does your child seem to respond less to sound now than they did when they were younger?	6+ mos	☐	☐
Does your child seem to turn more to one side than the other when sounds occur?	7 - 9+ mos	☐	☐
Does your child often seem to watch your lips while you speak?	12+ mos	☐	☐

(* Referral indicated)

Comments of Functional Skills

PLACE LABEL HERE

Begin questions at listed age at or closest to the child's age range. If two or more questions are missed, ask questions from the next lowest age range.

AGE (mons)	VISION	YES	NO	HEARING	YES	NO
1-2	Look at you, momentarily?	☐	☐	Startle to loud sounds (throws arms out)?	☐	☐
1-2	Blink or squint when brought into bright light?	☐	☐	Move arms or legs in time to speech patterns?	☐	☐
2-3	Like to look at your face when being held?	☐	☐	Quiet when he/she is upset and hears your voice?	☐	☐
3	Turn his/her head or eyes to watch you?	☐	☐	Look around to see what is making a new sound?	☐	☐
	Watch his/her own hands?	☐	☐	Look at toys or objects when they make sound?	☐	☐
	Bat at objects held above him?	☐	☐	Imitate vowel sounds like oo, ee, ah?	☐	☐
4-6	Smile at people other than just family?	☐	☐	React to a change in the tone of your voice? (i.e. happy, mad)	☐	☐
	Notice him/herself in the mirror?	☐	☐	Quiet when talked to with a soothing voice?	☐	☐
	Look around at his/her environment?	☐	☐	Move eyes toward the direction of sounds heard from the side?	☐	☐
6-9	Recognize your face across a room?	☐	☐	By 7 months look down if a sound occurs from below?	☐	☐
	Watch a rolling ball?	☐	☐	Aware of parent's voice when heard from a distance (next room)?	☐	☐
	Watch you as you write?	☐	☐	By 9 months looks up for a sound from above?	☐	☐
9-12	Stare at/grab your jewelry/glasses?	☐	☐	Watch TV for a short time (i.e. reacts to songs, rhymes, etc.	☐	☐
	Look for a toy that has dropped?	☐	☐	Turn or look when you say his name?	☐	☐
	Try to pick up Cheerio, raisin, lint?	☐	☐	Babble using a variety of sounds like baba, geegoo?	☐	☐
12-18	Reach into a container for food/toy?	☐	☐	Turn head quickly to locate sound from any direction?	☐	☐
	Build a 2-block tower or stack 2 things?	☐	☐	React to or show pleasure at new or unusual sounds (whistle, buzzer)?	☐	☐
	Match identical objects (i.e. 2 spoons)?	☐	☐	Responds to a simple command with no gestures ("come here", "sit down")	☐	☐
18-24	Reach into a container for food/toy?	☐	☐	"Dance" to music?	☐	☐
	Look for a missing object/person?	☐	☐	Let you know what he/she wants or needs by using their voice?	☐	☐
	Point to objects in the sky/out window?	☐	☐	Consistently use 20 or more words?	☐	☐
24	Look at picture details (a dog's nose)?	☐	☐	Point to some body parts when asked ("Where is your nose")?	☐	☐
	Point to pictures in a book?	☐	☐	Enjoy listening to stories?	☐	☐
	Like to scribble?	☐	☐	Understand many words (200+)?	☐	☐
30-36	Pretend to "pick up" objects from a book?	☐	☐	Identify different sounds (phone, doorbell)?	☐	☐
	Put an object into a small opening?	☐	☐	Listen to stories in a group of others?	☐	☐
	Copy or imitate drawing a line/circle?	☐	☐	Understand most things said to him him/her?	☐	☐

(Referral indicated if child is not performing two skills in the appropriate age range)

RECORD FINDINGS ON IFSP (Section 5)

PLACE LABEL HERE

INSTRUCTIONS

Family Hearing and Vision Report

(BN007)

A. PURPOSE

This form is to be used to screen child's vision and hearing prior to the initial IFSP (as part of the intake process) and annually thereafter (as part of the annual IFSP review.) The form is designed to gather information from the family about their observations and concerns, and to document evaluations completed to date.

B. USES

This form must be completed:

1. By the Intake/Service Coordinator (or designee) during the family orientation visit or at another time during the intake process; and
2. By the Service Coordinator annually as part of the annual IFSP review.

C. INSTRUCTIONS

1. Identifying Information

   Enter child's name, date of birth and current age.

2. Previous Testing

   a. Vision

      (i) Check boxes as appropriate for questions about parent concerns, previous referrals for evaluations, and testing completed to date.

      (ii) If physician has made a diagnosis, enter diagnosis and provider's name.

   b. Hearing

      (i) Check boxes as appropriate for questions about parent concerns, previous referrals for evaluations, and testing completed to date.

      (ii) If physician has made a diagnosis, or audiologist has documented hearing loss, enter information and provider's name.

      (iii) Ask parent if child had a newborn hearing (*First Sound*) screening prior to hospital discharge.

      If **YES**, enter test date and results: Pass (both ears) or fail (either or both ears). If failed and no referral or follow up, hearing evaluation is required.

      If **NO**, hearing evaluation is required. Hearing screening was not completed at birth, or the child failed the newborn hearing screening.

   c. If any diagnosis is revealed in this section STOP. Skip "Risk Factors" and "Functional Skills" sections of the form. Enter finding on IFSP (Section 5).

3. Risk Factors

   a. Ask parent or informant about the listed risk factors.

   b. If any risk factors are present check "YES".

4. Functional Skills

   a. Red flag questions (Y/N)

      (i) Ask all vision red flag questions.

(ii) If answer to *any* question is YES, referral for evaluation is indicated.

b. Skills questions

(i) Begin questions at listed age at or closest to the child's age range.

(ii) If two or more questions are missed, ask questions from the next lowest age range.

(iii) If the child has delays across multiple domains, functional skill development for hearing or vision may not be at chronological age level.

In that case, it's important to consider the relative amount of developmental delay of the child and consider his or her vision and hearing skills at *that* level.

Example: An 18-month old child found to have skills equivalent to a 12-month level, would need to have 2 out of the 3 skills checked in the 12-month section to have "passing" vision skills.

(iv) A referral for evaluation is indicated if an overall developmental delay in multiple domains is <u>not</u> suspected, and the child has missed two or more questions from his/her age range.

(v) If concerns are present, they should be indicated and the interviewer should probe the family member(s) for more information.

5. Document results on IFSP form (Section 5)